



Our health, our care, our say: making it happen

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Foreword



Our health, our care, our say: a new direction for community services set out a new and ambitious vision for the future of our community services, responding to what people want and expect of services in the 21st century. In the consultation and debates that preceded the White Paper, they told us very clearly what they are looking for: seamless health and social care to support them to stay healthy and to lead independent lives; more services provided locally; and services that are fair to all, with more help for the people who need them most.

Acute hospitals are places where people go when it is really necessary, not as a matter of routine. So community services need to take centre stage in the health and social care system of the future. Implementing the White Paper will involve a fundamental shift to provide care closer to home, where the overwhelming majority of people's daily contacts with services take place, and where the services can fit around the lives people want to lead.

This shift is necessary, not only because it responds to what people want, but also because the needs of today's and tomorrow's users of health and social care services are very different from those of yesterday. Local services are at the frontline in developing preventive approaches and helping people to make healthy choices, in environments that support their physical and mental health and well-being. They are central to supporting independence and quality of life for the growing numbers of people with long-term needs, for whom care truly starts in the home.

I do not underestimate the challenges involved in making these changes. They cannot happen overnight. However, the White Paper vision is achievable. It empowers the thousands of staff dedicated to improving support and well-being for people in their communities and to use their creativity to improve care. In the last nine months real progress has been achieved. This report showcases some of the leading-edge work – on trialling individual budgets in social care, developing new approaches to prevention, and shifting care out of hospitals – that is underway locally and that is starting to make the White Paper a reality.

We have also made progress in developing the mechanisms and frameworks that will enable and support achievement of the White Paper aims. Through the changes that are underway in the health and social care systems we are putting real power and responsibilities into the hands of local commissioners and individuals who use services.

Direct payments and individual budgets are pointing the way to new levels of choice and control for people who need support from social care services. Practice based commissioning gives primary health care teams the freedom and incentives to develop new models of support, to strengthen prevention and early intervention, and avoid unnecessary admissions to hospital. And the changes we are making to strengthen the commissioning role of PCTs gives them the opportunities and the tools to drive development of services in partnership with local communities to respond to their needs.

We are also increasing the opportunities for partnership between local authorities, the NHS and the third sector to support new approaches to care, and to tackle the inequalities in provision, and in outcomes, that persist in many areas. Some 70 per cent of PCT boundaries are now coterminous with local authorities, offering real opportunities to strengthen partnership work in many areas.

Local Area Agreements (LAAs) are also starting to act as a catalyst for joint planning so that services can work together to make a real difference. These will increasingly be underpinned by joint commissioning.

Looking forward, services need to use these new mechanisms and the other tools and developments we describe in this report to help them concentrate on:

- ensuring that changes put people at the centre of their care and developing the local partnerships that are needed to support them;
- getting upstream on prevention, early intervention and support for individuals for self care, and promoting well-being for the wider population; and
- planning how to shift care – not just shifting activity from one big building into another smaller one, but developing models of care that support people in communities and in their homes; reducing unnecessary admissions to hospitals and institutions; and getting in early to stop problems developing.

Putting these principles at the heart of everything we do – whether in designing the framework within which services operate or in commissioning and delivering local services – is the route to high quality, sustainable services that meet people’s expectations of modern health and social care support. The White Paper was developed in partnership with people who use services and with those who are responsible for them. That approach holds good into the follow-up development work and implementation. Together we can make it happen.



Secretary of State

Introduction

1 The White Paper *Our health, our care, our say: a new direction for community services* was published at the end of January 2006. It followed the Green Paper on adult social care *Independence, Well-being and Choice*, and drew on an extensive public consultation exercise in which members of the public were asked about their priorities for health and social care. The White Paper was also shaped by views from those working in the health and social care sectors, in particular through recommendations from five policy taskforces made up of representatives from major stakeholder organisations.

2 The White Paper set a new direction for social care and community health services with four main goals:

- Better prevention and early intervention for improved health, independence and well-being
- More choice and a stronger voice for individuals and communities
- Tackling inequalities and improving access to services
- More support for people with long-term needs.

3 *Our health, our care, our say: making it happen now* provides an update on progress on implementation to date against those goals, and a brief forward look to the next stages. It does not comment on every commitment, but concentrates on those areas where early substantial progress is being made. The report sets out in Chapter 1 a 'Road map' to implementation. This is intended as a resource for local partners, listing those tools and products already (or soon to be made) available and key actions that can be undertaken locally to support implementation.

4 As the proposals in the White Paper are developed and implemented we will be assessing the effect that changes in the delivery of services will have for a wide range of population groupings. This includes disabled people and black and minority ethnic groups, as well as for the population as a whole.

5 Support for implementation is being provided, in particular to pilot sites, by a range of agencies in partnership, including the Care Services Improvement Partnership (CSIP), the NHS Institute for Innovation and Improvement (NHSI), the Improvement and Development Agency (IDeA), the Integrated Service Improvement Programme (ISIP), the Improvement Foundation, and national support teams for health improvement.

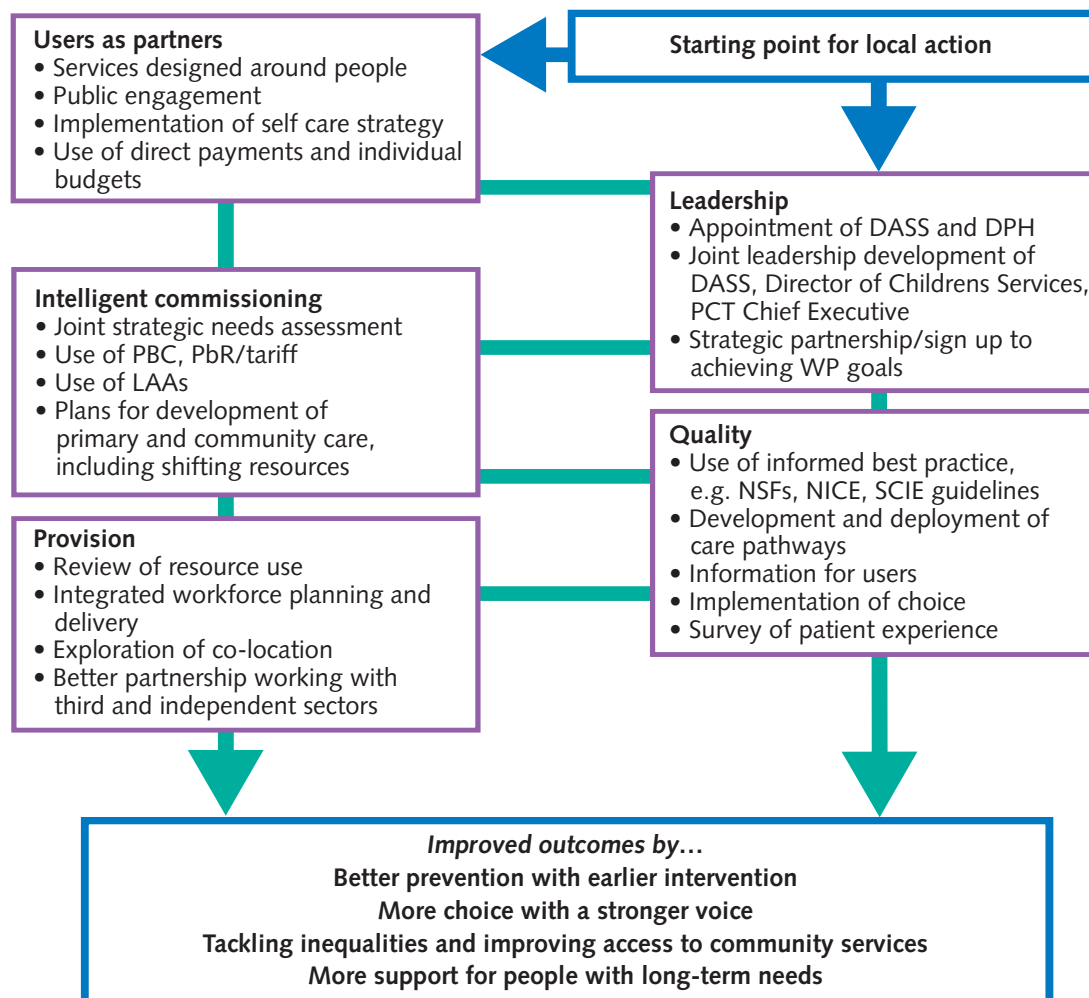
1 Making it happen – bringing about change locally

'Road map' and actions for implementation

1.1 The diagram below sets out a guide for how the goals of the White Paper can be realised through local action. This should begin with the key principles of engaging service users in the design and development of services, combined with strong local leadership in the health and social care sector. Service design should then utilise

recent innovations in commissioning, increased flexibility and partnership in provision, and developments in quality to produce the improved outcomes, which are at the heart of the White Paper.

1.2 The following section sets out a 'Road map' for implementation, detailing how local action along these lines is turning the White Paper commitments into reality.



1.3 The following section sets out:

- key goals for White Paper implementation and what implementation would look like
- actions that local services/partnerships can undertake to improve services
- tools and products that the Department of Health and others will be producing to enable implementation
- early implementer/demonstration sites (see *Making it happen: pilots, early implementers and demonstration sites*).

The goals of the White Paper – what will successful implementation look like?
<p>Better prevention and early intervention for improved health, independence and well-being</p> <ul style="list-style-type: none"> • A reduction in the prevalence of damaging underlying determinants of health (e.g. smoking and obesity) and associated service usage • A reduction in numbers of people who are out of work or unable to work due to ill-health or dependency • A shift in resources and in planning emphasis to prevention and early intervention, supported by robust cost-benefit analysis • Increased self care and condition management among service users • More people who need care being supported to live in their own homes
<p>More choice and a stronger voice for individuals and communities</p> <ul style="list-style-type: none"> • Service users and their carers having more say over where, how and by whom their support is delivered, and better access to information that helps them make their own choices about this • Individuals and their communities being able to influence the shape and delivery of local services, and to trigger action to look at problems • People using services being more satisfied with their overall experience of care
<p>Tackling inequalities and improving access to services</p> <ul style="list-style-type: none"> • More services being provided in the community through: <ul style="list-style-type: none"> – promoting emotional health and well-being, and stronger services and support for people to help prevent physical and mental illness – ensuring that people are discharged from hospital with appropriate community support – better support for individuals in their own home through services and using new technologies, preventing unnecessary admissions into residential or hospital care – more services moving out of acute hospitals into community settings, where services can be delivered safely and secure benefits to service users • An improved range of services for urgent care • Streamlined GP registration and appointments processes to improve access and convenience • Local health and social care communities working together to understand and address inequalities

More support for people with long-term needs

- Service users with long-term needs and their carers receiving supportive services that respond to their preferences and choices, in a location convenient to them
- More support for self care, including increased participation in the Expert Patients Programme, and take up of the Expert Carers Programme
- Ongoing reductions in avoidable hospital admissions
- Health and social care services becoming better co-ordinated to meet the needs and wishes of individuals with long-term needs

Local actions for implementation

ongoing

Partnerships:

- make effective use of Local Strategic Partnerships and LAAs, including the development of sustainable community strategies;
- develop and implement a range of care pathways;
- support development of responsive provider models, e.g. social enterprise;
- explore current and potential community resources, including workforce, community hospitals, third sector, independent and social enterprise provision; and
- create End of Life networks

PCTs:

- use practice based commissioning, PMS/APMS, enhanced services, PbR and choice to drive service redesign;
- learn from PCTs' systematic review of services in relation to equity/quality and value for money;
- act on the results of PCTs 'Fitness for Purpose' assessment;
- review, and test, decisions on community hospitals and capital procurement plans;
- increase the use and scope of local pharmacies; and
- establish local sexual health networks.

Local authorities:

- establish challenging local targets for take up of direct payments; and
- facilitate replacement of patient forums with local involvement networks (LINKs).

Implement:

- *Health Challenge England – next steps for Choosing Health;*
- National Service Frameworks;
- *Making it Possible: Improving Mental Health and Well-being in England;*
- *Everybody's Business-Integrated mental health services for older adults: a service development guide;*
- *Achieving positive shared outcomes in health and homelessness;*
- *Supporting people with long-term conditions to self care;* and
- *Lead Professional Good Practice Guidance for children with additional needs.*

	<p>Transfer lessons from implementation of:</p> <ul style="list-style-type: none"> • <i>Every Child Matters</i> and Children's Trust development, including joint commissioning and joint provision; and • 'different' prescription schemes – including exercise and well-being prescriptions.
2006/07	<ul style="list-style-type: none"> • Joint strategic local needs assessment to inform commissioning decisions • LAA negotiations and refresh by March 2007 • Commissioning of Expert Patients and Carers programme places • Development of practitioners with a special interest (PwSI) roles
2007/08	<ul style="list-style-type: none"> • Inclusion, in PCT Local Delivery Plans for the 2008 planning round, of a clear strategy for the development of primary and community care, including ambitious goals for the shift of resources • Delivery of short-term home based respite care for carers in crisis or emergency situations • Integrated care plans for everyone with both long-term health and social care needs expected by 2008 and for everyone with a long-term condition by 2010 • Establishment of joint health and social care teams and/or networks to support those with long-term conditions by 2008 • Appointment of DASS and Directors of Public Health (DPH) by 2008
2008/09	<ul style="list-style-type: none"> • Action planning to ensure alternative provision to enable closure of NHS learning disability campuses by 2010

Tools/products to support implementation	
Expected publications (2006/07) to aid implementation:	
<ul style="list-style-type: none"> • Commissioning framework for health and well-being • Consultation on development of PbR 2008/09 and beyond • Consultation on development of choice programme • Consultation on proposals for the future role of the independent regulator • Publication of <i>Options for Excellence Review of the social care workforce</i> 	
2006/07	<p>Commissioning:</p> <ul style="list-style-type: none"> • Commissioning frameworks (<i>Health Reform in England – update and commissioning framework</i>) (July 2006 and winter 2006) • Development of local triggers and petitions (2007) • Following current consultation, the publication of a national framework for NHS funded continuing care (2006/07) <p>Service delivery:</p> <ul style="list-style-type: none"> • Development of urgent care strategy • <i>Our health, our care, our community: Investing in the future of community hospitals and services</i> and related capital funding (2006) • Establishment of Social Enterprise Fund and delivery of Social Enterprise Pathfinders (2006/07)

Primary care:

- Exploring incentives for practices to expand – review of primary medical care contracts (2006/07)
- Nationally led, locally tailored procurement waves supporting equitable provision of primary care (2006/07)

Patients as partners:

- Framework for choice, incorporating information for choice (2007)
- Creation of Expert Patients Programme community interest company with increased investment (2006)
- Development of information prescription and piloting an integrated approach to provision, and searching, of information (2006/07)
- Development of Expert Carers Programme (2006/07)

Integrated tools:

- Integrated care planning guidance (2007)
- Support for integrated workforce planning (2006/07)
- Tool to assist in audit of children's palliative care

Health and well-being:

- *Informing healthier choices: Information and intelligence for healthy populations – revised strategy*
- Evidence base of interventions supporting health and well-being, report on definitions and measures of preventive health spend (2006/07)

2007/08

- Indicative unbundled tariff for diagnostics and acute phases of care
- Health Direct to provide a comprehensive source of NHS accredited information advice and practical support for healthier lifestyles
- Development of regular comprehensive health checks for individuals with learning disabilities (2007)*
- Development of standards, and extension of eligibility, for patient transport services
- New GP registration rules*, including:
 - clarifying closed-list procedures
 - guaranteeing acceptance onto an open list
 - creation of obligations for the provision of up-to-date information on practices (2007/08)
- Establishment of a carers' information/helpline (2007/08)
- Dissemination of emergency home based respite care best practice
- Alignment of budget cycles for NHS and local authorities (beginning 2007/08)
- Patient and Public Involvement resource centre best practice guidance

*Contingent on the 2006/07 contract review.

2008/09	<ul style="list-style-type: none"> • Evaluation report into community care/equipment services self-assessment pilots (2008) • Aligned health and social care inspection and performance assessment regimes (2008) • Intended evolution to Quality and Outcomes Framework for GPs, to provide a focus on health and well-being outcomes (2008/09) • Single complaints system across health and social care (2009)
Timescale to be confirmed	<ul style="list-style-type: none"> • Updated Prime Minister's 1999 Strategy for Carers • Common assessment framework • Direct payments legislative changes

Lessons from national early implementer/demonstration sites	
Starting 2006	<ul style="list-style-type: none"> • Selection and start-up of National Bowel Cancer Screening Programme local screening centres • Evaluation of large scale workforce pilots findings (2006) • Key learning and evidence base from Partnerships for Older People Projects (2006 onwards) • Learning from examples of new care pathways, for example '<i>Do once and share</i>' and NHS Institute shifting care sites
2007 and beyond	<ul style="list-style-type: none"> • Evaluation of self-referral to therapies (2007) • Shifting Care demonstration sites report (2007) • Report from the self-directed support network to the Prime Minister on the potential for individual budgets (summer 2007, final evaluation of whole project April 2008) • Early findings from Integrated Care and Assistive Technologies pilots (2008) • Development and evaluation of NHS 'Life Check' (pilots to go live in 2007) • Health Direct pilots to be developed and to go live • Evaluation of psychological therapies demonstration sites 2007 • Development and review of information prescriptions • Review of common assessment framework and needs assessment modernisation sites

2 Progress against White Paper goals

2.1 Over the last nine months we have been putting in place some of the major building blocks for achieving the White Paper goals.

Better prevention and early intervention for improved health, independence and well-being

2.2 People said they wanted to take more control of their own health and well-being, but wanted more support to do this.

NHS 'Life Check'

2.3 The NHS 'Life Check', which will be a two-part service – a self-assessment followed by personalised advice and support for those shown to be at risk – is aimed at helping people to assess the risk of ill-health created by their own lifestyles.

2.4 Initially, NHS 'Life Checks' are being developed for use at three key life stages – the first year of life, adolescence and mid-life (age 50–60). Work with partners has begun to develop off-line and paper-based prototypes of a self-assessment questionnaire for each of these NHS 'Life Checks'.

2.5 Piloting will take place in a range of settings in spearhead sites across the country. The adolescent NHS 'Life Check' is being co-developed in the four adolescent health demonstration sites in Bolton, Hackney, Northumberland and Portsmouth,

and will be piloted from early 2007. Pilot sites for the NHS 'Life Check' for children in their first year of life and their parents, and for people around 50 years of age will be identified by spring 2007.

2.6 By early 2007 around 1,200 health trainers will be working in different sectors and will provide follow-up help and advice for those shown to be at risk.

Improving access to psychological therapies

2.7 Millions of people suffer from mild to moderate mental health problems, and treating them takes up about a third of GPs' time. Psychological therapies offer a real alternative to medication.

2.8 Two demonstration sites have now gone live – in Doncaster and Newham – and will aim to deliver real benefits for 7,700 people over the 18 months of the pilot. Both sites are providing increased access to evidence-based psychological interventions such as cognitive behavioural therapy (CBT) in community settings, as well as computerised cognitive behavioural therapy (cCBT).

2.9 The Care Services Improvement Partnership (CSIP) regional development centres are also starting smaller scale pilots, aimed at providing evidence of the effectiveness of these treatments in different settings and on different scales.

2.10 The national and regional demonstration sites will collect evidence of the effectiveness of providing increased access to psychological services, assessing:

- clinical effectiveness and well-being;
- employment status and economic impact;
- provision of service user choice; and
- service user satisfaction.

2.11 During 2006/07 we will explore the viability of rolling out these new service models to other centres across England in the light of these findings.

Partnerships for Older People Projects (POPP)

2.12 Older people told us they want support to stay in their own homes, play an active part in their communities, and have access to services that treat them with dignity and respect. The White Paper commits to expanding the evidence base about how new kinds of local partnerships and financial arrangements can support this.

2.13 The POPP pilots bring together a range of interventions, chosen because of their combined potential to improve outcomes for older people and to reduce hospital admissions and residential care stays. They will help lay the foundations for a sustainable shift of resources and culture towards prevention across the whole health and social care system.

2.14 The 19 first-phase projects went live in May 2006, with funding of up to £41 million during 2006/07 and 2007/08. Some £18.5 million is to be made available for second-phase projects that will run from 2007/08. Details will be announced in December 2006.

2.15 A national conference in December 2006 will present the early findings from the first-phase POPP sites. An interim progress report from the national evaluation of POPP will be produced in spring 2007, and the final evaluation report will be published by the end of 2008.

POPP pilot: Linking older people into the community

'Community Links' is a home support service working with older people in Leeds to reduce isolation and to improve quality of life.

One of their recent clients was living in a dirty flat in a sheltered housing complex, with little contact or support from local services. He was not getting his full benefit entitlement and he was not getting on well with other residents.

Now, after several visits, 'Community Links' has helped him to find new accommodation. He has been referred to a consultant and this highlighted numerous medical problems, including his liver, kidneys and prostate, which are now receiving attention.

He had a full benefit check, is getting on better with other people, and now has a good working relationship with the warden. 'Community Links' has also performed advocacy services on his behalf with his GP and hospital staff, helping him make informed choices.

Commitment	Progress	Next Steps
<p>Fitter Britain. The Olympic and Paralympic Games in London in 2012 provide a unique opportunity to promote a fitter, healthier, more active Britain.</p>	<p>A Health and 2012 delivery plan, which sets out how the Games will be used to secure wider benefits to health, was consulted on during September 2006.</p> <p>The 'Fitter Britain' campaign is supported by a cross-government initiative called 'Small change, big difference' launched in April 2006. In August 2006, Caroline Flint was asked by the Prime Minister to take responsibility for looking at how government can collectively encourage people to increase their levels of physical activity, and minimise the barriers to people doing this.</p>	<p>All partners can play a role in the promotion of the messages of 'Small change, big difference' and help to encourage a shift in the public's attitudes towards healthy lifestyles.</p> <p>Caroline Flint is leading an inter-ministerial group to develop a strategy for transforming the population into a fitter and more active nation in the run-up to the 2012 Olympic and Paralympic Games.</p>
<p>Local Leadership: Directors of Adult Social Services (DASS) and Directors of Public Health</p>	<p><i>Guidance on the Role of the Statutory Chief Officer Post of the Director of Adult Social Services</i> was published in May 2006.</p> <p>The DASS will provide a key leadership role in respect of adult social care and will, together with Directors of Children's Services and Directors of Public Health, ensure improved partnership working across health and social care services.</p> <p>Regional Directors of Public Health will lead the public health agenda in the government regional offices and Strategic Health Authorities (SHAs).</p>	<p>PCTs are currently appointing their senior teams, including Directors of Public Health, whom they are encouraged to appoint jointly with local authorities. They will work jointly with DASS and Directors of Children's Services to develop comprehensive plans, in conjunction with local people, that will lead to improvements in community health and well-being and a strong case for investment in prevention.</p> <p>We intend to bring forward legislation to require councils with social services responsibilities to appoint an executive member whose portfolio of responsibilities must include adult social care.</p>
<p>NHS Bowel Cancer Screening Programme</p>	<p>A national Bowel Cancer Screening Programme in England has now commenced a three-year roll-out. Eventually, every year around two million men and women in their 60s will benefit from screening under the programme. The programme is being co-ordinated by the NHS Cancer Screening Programme (CSP).</p>	<p>The selection and start-up process for a further 75–85 local screening centres will be undertaken in two waves in 2007/08 and 2008/09, with SHAs ensuring the suggested locations meet the needs of the local population.</p>

More choice and a stronger voice for individuals and communities

Control and voice

2.16 We know that the public want choice and input into health and social care services, and we are working to create a system where these can act as drivers to service improvement.

Direct payments and individual budgets

2.17 The White Paper made commitments to extend the availability of direct payments to groups of people currently excluded from receiving them, and to increase awareness and boost the uptake of direct payments. It also committed the Government to piloting the use of individual budgets.

2.18 Direct payments are a way for people who need support to have more control over the services they receive. People receive money direct from the local authority and purchase services themselves. Numbers of direct payments are already a key performance indicator within the performance framework that the Commission for Social Care Inspection uses when inspecting local authorities. We are working to increase the take-up of direct payments. This work will be based on research and is being undertaken in collaboration with key stakeholders. Working with CSIP, we will gather and disseminate good practice and increase awareness of the benefits of direct payments among local authority frontline workers, senior staff and elected members, as well as among people who need support and their carers.

2.19 Individual budgets build on some of the features of direct payments by increasing people's choice and control over the way they are supported. As well as social care funding, they bring together different resource streams that an individual might receive, for example Access to Work and Independent Living Funds, and allocate a single transparent sum to them. Individuals can choose to receive this in the form of a direct payment, as council-provided services, or as a mixture of cash and services up to the value of their total budget.

2.20 Work has already begun to pilot individual budgets in 13 local authorities. The pilots will test individual budgets for older people, people with a physical disability or sensory impairment, people with learning disabilities, people with mental health issues, and young people moving into adulthood. They will provide evidence about the cost of the approach and whether it delivers benefits for these different groups of people. To gather this evidence, a research team is undertaking a comprehensive evaluation of the pilots.

2.21 CSIP is providing implementation support to the pilot sites and helping to disseminate information among them and – as the approach develops – other local authorities. The Individual Budgets website will enable the spread of good practice and learning and a support network for local authorities interested in developing approaches to self-directed support. The network is being established from October 2006. It will also explore the possibility of extending individual budgets – for example to include further income streams – and will report on this in the summer of 2007.

Individual budgets for life

Julia is married with an 11-year-old son. She has been disabled for 13 years and has been using social services for 10 years.

Initially, Julia was provided with direct services by her local authority, where care staff came when they could and did what was written on her care plan. Julia switched to direct payments in 1998 and enjoyed the new freedom of being able to choose who cared for her, when they did it, and what they did.

Although she was sceptical about what more they could offer her, in 2006 Julia received an individual budget. In contrast to her previous experiences, Julia's assessment looked at what was most important in her life and what she considered needed to change. Julia was given a budgetary figure for the whole year and – together with a support planner – planned how she would spend the money to meet her needs.

As a result, Julia has not just spent money on personal assistance, but has bought lightweight modular ramps to make her house accessible for her wheelchair, air conditioning to help her breathing and reduce her admissions to hospital, and an accessible patio to help her to use her garden.

Julia says “Direct services allow you to survive at home, direct payments give you more choice and control over your life. Individual budgets allow you to live!”

A stronger local voice

2.22 In July we published *A stronger local voice: A framework for creating a stronger local voice in the development of health and social care services*, completing the fundamental review of public and patient involvement designed to strengthen arrangements for a local voice in health and social care. Key points are:

- replacing patient forums with local involvement networks (LINKs), to provide a flexible means for communities and groups to engage with health and social care organisations;
- promoting public accountability through open and transparent communication with commissioners and providers; and
- simplifying and strengthening the duties on health care organisations to involve and consult, as well as placing a new duty on health care commissioners to respond to what patients and the public have said.

2.23 In the autumn we will publish an essential guide to engagement and consultation practice on changing health care services. This will support effective engagement on service change.

Local triggers: service user and community involvement

2.24 *Health reform in England: update and commissioning framework* consultation sets out how the public will be able to trigger reviews of local services by PCTs where there is cause for concern. This can be done either through a petition, or via LINKs raising concerns with local authority overview and scrutiny committees (OSCs). Following the consultation, guidance on the application of the triggers will be published in the autumn.

Patient Experience Survey

2.25 The Patient Experience Survey is being used to assess the impact of the 'improved access scheme' and 'choose and book'. More than four million GP patients will be surveyed in early January 2007. A questionnaire is being designed to ask patients about their experience of:

- consulting a GP within two working days;
- booking a 'non urgent' appointment with the GP;
- contacting the practice by telephone; and
- whether they could consult a 'preferred' GP if they were prepared to wait.

2.26 Separate arrangements are being made for the 'choice' question in 2006/07. This will ask whether patients recall a conversation with their GP about choice when referred for a first consultant outpatient appointment (for those procedures where 'choice' applies).

2.27 We are committed to the concept of the Patient Experience Survey as a mechanism for incorporating patient experience in assessing the success of policies and improving health care. In due course, the Patient Experience Survey could be used across a wider range of health services, not just GP services.

End-of-life care strategy

2.28 A national end-of-life care strategy is being developed to deliver increased choice to people near the end of their life about where they are cared for and where they die. This will involve:

- establishing end-of-life care networks to improve co-ordination between services and help identify people in need;
- extending the existing end-of-life care programme to ensure that all staff who care for people who are dying are properly trained; and
- investing in community-based specialist palliative care services to provide rapid response and Hospice at Home services.

2.29 A £50 million capital investment programme for hospices was announced in September 2006 including £40 million made available through the 'Dignity in Care' programme for the refurbishment of hospice facilities for older people. Up to a further £10 million will be made available direct to Marie Curie Cancer Care, subject to a successful business case, to support their programme of major capital investment works.

2.30 A local audit of provision of services for disabled children or those with palliative or complex needs will assist in developing the right models of care for children. A tool to assist PCTs to carry out this audit is being developed by CSIP.

Delivering choice at the end of life

Marie Curie Cancer Care, through their Delivering Choice Programme pilot sites in end-of-life care networks in Lincolnshire, Tayside and Leeds, are helping develop a model to deliver the best possible palliative end-of-life care, including care that reflects patient choice. These three Delivering Choice Programme (DCP) projects are working across organisational boundaries. Key to all these pilots is partnership working between social services, acute and ambulance trusts, local PCTs and voluntary sector pilots.

Detailed planning identified barriers to people receiving their choice of care, and the location of that care. In Lincolnshire this has already led to service changes.

The Palliative Care Co-ordination Centre co-ordinates health and social care packages, helping support 360 people in a six-month period. This approach is releasing, on average, four hours of

nursing time per person for more care. The intention is that the Centre's remit will expand so that it co-ordinates professional education requirements and acts as an information source for service users and carers.

The Rapid Response Team provides a range of services, including twilight and out-of-hours rapid response nursing care, planned care, crisis interventions and telephone advice. Through the provision of over 700 'episodes of care' to over 250 patients, it is estimated that around 280 potential hospital admissions have been avoided.

Where people are admitted to hospital, the new Community Discharge Liaison Nurses are helping support people to return home. The improved discharge procedures mean that nearly three-quarters of palliative patients in their care are now leaving hospital within three days.

These changes are helping services to meet the needs of the majority of people who express a preference for dying at home.

Commitment	Progress	Next steps
A common approach to risk in social care.	Work is underway to produce a framework of guidance and good practice. The common approach will focus on social care services, but will also include multi-disciplinary working.	We will aim to issue the framework for consultation in late 2006, with a view to publishing material in early 2007.
Integrated information and 'information prescriptions'. Good information enables individuals to make informed decisions about their own care or the services they receive.	A review of the practicalities of providing local services information is currently underway. This is due to report early in the new year. An 'information prescription' for individuals with a long-term condition and a long-term need for social care, and their carers, is being developed. Piloting will begin in autumn 2006 in the areas of cancer, mental health and vulnerable older people.	By 2008, we would expect everyone with a long-term condition and/or a long-term need for support to routinely receive information about both their condition and available self care support services.

Tackling inequalities and improving access to services

2.31 People have told us they want more local and convenient care. Technology and service developments are making this possible, and are also reducing the number and length of hospital stays. People also told us they wanted better access to GP services at times that were convenient to them.

More local and convenient care

2.32 We know from the *Your health, your care, your say* public listening events that people want more local and convenient care closer to home, even if that means changes to local hospital services. They believe that providing care closer to the communities where they live will improve satisfaction and aid people in their recovery by taking away the need for repeated long trips to hospital.

2.33 We have been working closely with the Royal Colleges and speciality associations to investigate how care currently provided in hospitals can be made more local and convenient. We have identified 30 innovative sites that are demonstrating how teams of hospital consultants, GPs, nurses and allied health professionals can safely and effectively provide operations and diagnostic tests in a more local, convenient, integrated fashion. These include 'step-down' facilities near to people's homes. The sites have adopted various approaches, including consultant-led clinics provided in community settings; surgery led by specially trained GPs; nurse-led services; dedicated telephone follow-up systems, and home chemotherapy.

CASE STUDY

Diabetes care in Leicestershire

People with diabetes in South Leicestershire PCT are benefiting from more local care. People, who would have been referred to hospital, are now being seen at community clinics or in their own homes by Community Diabetes Specialist Nurses. Focusing on referrals for poor glycaemic control on insulin, insulin transfer and education for newly diagnosed individuals, care is being delivered closer to home, with the project also supporting and promoting active self care and awareness.

One user of the service, a 70-year-old woman diagnosed with Type 1 diabetes, was referred to the community team by a

hospital diabetes specialist after starting insulin. As a full-time carer for her husband, she finds it hard to leave him on his own and was anxious about having to make regular trips to the hospital. She has been reassured by the new community services:

"To know that you're only a phone call away, or a quick visit on the same day to your local diabetic nurse for essential advice, is very reassuring. Diabetes can be very frightening. A one-to-one consultation with a local diabetic specialist, or even a home visit by her, is wonderful and it does instil confidence. I know it does from my own experience."

2.34 The sites will be thoroughly evaluated, with best practice and lessons learned then being used to spread innovations over a wider area. A steering group that includes the heads of a number of Royal Colleges and professional bodies will make recommendations in 2007 about which models are appropriate for adoption nationwide.

2.35 Progress on shifting care is also being made in other areas. For example, the current review of General Ophthalmic Services, and the piloting of new eye care pathways, will help to define how the NHS can develop a wider range of community-based eye care services that are more convenient and accessible to patients.

Community hospitals and services

2.36 In order to shift care, there will be a need for high quality services in locations that are convenient to users. The White Paper made it clear that we would support PCTs by investing in a new generation of community hospitals and services, grounded in local communities and fostered by local partnerships, which support independence and well-being.

2.37 *Our health, our care, our community: investing in the future of community hospitals and services*, was published in June 2006. It announced that up to £750 million capital will be available over the next five years to develop a range of different models for new community hospitals and services. It invited a first wave of tenders, which need to be submitted by PCTs through their SHA, by 21 October 2006, with a second wave following by 31 December 2006.

Urgent care

2.38 When people need care urgently they want it to be available quickly and close to, or in, their own homes. They need access to advice and care that will keep them safe. Changes in medical technologies and changes to the NHS and social care workforce make it possible to provide that care differently. The White Paper gave a commitment to develop a framework for urgent care that PCTs and local authorities can use to improve patient and user experience, including by reducing unnecessary hospital admissions.

2.39 On 4 October 2006 we published a consultation document *Direction of Travel for Urgent Care: a discussion document*, asking staff and service users how urgent care services can be improved in the future. The results of this consultation will help us develop and deliver a Strategy for Urgent and Emergency Care, which will be published in spring 2007.

2.40 Locally it makes sense to review the range of services available in each health and social care community. Services need to be developed that:

- are more responsive to people;
- are more efficient in the way resources are deployed; and
- make the most of opportunities from medical and technological advances to deliver better care and convenient support for people.

Commitment	Progress	Next steps
<p>Increasing primary care provision. New providers can help increase service provision in areas with the fewest number of GPs, thereby reducing inequality of access.</p>	<p>We are working with the 30 PCTs with fewest GPs on a nationally coordinated but locally defined independent sector procurement to increase capacity and improve access. We aim to publish service specifications in early 2007 with the first new services commencing during 2007/08. We are also exploring the potential to open up the initial procurement wave to other PCTs with relatively poor primary medical care provision.</p>	<p>Future procurement waves will be shaped around the ongoing needs of the local population.</p> <p>Local care communities, with third sector providers, should already be working together to explore options for improving local provision.</p>
<p>Improving access to primary care. Primary care, and GP practices in particular, need to be responsive to the needs of their communities.</p>	<p>A range of measures will support general practices in becoming more responsive, including:</p> <ul style="list-style-type: none"> • the ability to choose a GP whose opening hours suit the patient; • incentivising practices to expand and offer opening hours and services which attract patients; and • the availability of convenient alternative services. 	<p>Contingent on the 2006/07 contract review, new eligibility rules and a revised patient registration process for general practice will be introduced from April 2007, enabling patients to benefit by:</p> <ul style="list-style-type: none"> • streamlining the registration process; • ensuring patients have the right information to choose a practice; and • guaranteeing acceptance onto an open list.
<p>Self-referral to physiotherapy. To evaluate new approaches, including allowing patients to access treatment and advice from physiotherapists without having to see their GP first.</p>	<p>Following initial work with the Chartered Society of Physiotherapy and other partners, potential pilot sites have been working with their stakeholders to develop a service that will be sustainable and best meets people's needs.</p> <p>A definition of self-referral has been agreed with the professional bodies representing the allied health professions. This will distinguish self-referral from other terms, such as 'open access' and 'direct referral'. This ensures a consistent approach to any action following the recommendations from the pilots.</p>	<p>Pilot sites will be announced in autumn 2006.</p>

CASE STUDY

Better services for people with long-term conditions in Dudley

In Dudley PCT the drivers for care closer to home and 'The Right Care in the Right Place' led clinicians, managers and social care colleagues to work together to redesign services, resulting in a model that would see investment in community services and the development of new roles rise dramatically.

One such service is the Community Heart Failure Service. Here nurses conduct community clinics and provide a home treatment service to prevent patients having to travel to hospital. As Director of Nursing, Claire Old, says: "A holistic view of the patient can be taken as the wider determinants of health, such as housing

and environment can be assessed alongside clinical symptoms." Strong links remain with hospital consultants, so that specialist opinions can be obtained very quickly. Maggie Williams, clinical manager of the service, explains: "This is often not necessary, as the growing expertise of the nurses and the fact that some members of the team can now prescribe many of the drugs necessary for fast, effective treatment means that we can head off a deterioration in the patient's condition very swiftly."

Ron Lane, a patient of the service, feels that the home treatment service is his lifeline: "My nurses are there to help me stay safely at home with my family rather than in hospital. With the support of these wonderful people I can live the rest of my life with hope."

More support for people with long-term needs

2.41 The 15 million people in England with long-term conditions are the biggest consumers of health and social care, and they want services to work together more effectively to support them. People with long-term conditions are true experts in their own care. Involving them in decisions about their care will ensure that their needs are met.

Expert Patients Programme

2.42 The Expert Patients Programme (EPP) is a peer-led self-management programme to support people with long-term conditions to manage their condition better and

improve their quality of life. The White Paper committed to increasing the number of EPP course places from 12,000 to 100,000 per year by 2012. A community interest company (CIC) is being established to administer the programme, providing new opportunities for marketing and delivering the EPP. We will treble investment in the EPP and support the transition to a CIC.

2.43 The chair and non-executive directors of the company have been appointed and have held their first shadow board meeting. The company is expected to be incorporated in October 2006, and the transfer of resources, EPP staff and assets will be completed by the end of 2006.

Whole-systems, long-term conditions, integrated care and assistive technology pilots

2.44 Many exciting developments are improving the way we provide comprehensive care for people with long-term needs. The White Paper commits to considering these developments and building, on a credible scale, an evidence base of the effects of a whole-systems approach to long-term conditions, including effects on quality of life and reduced acute hospital usage. Smaller scale international evidence suggests emphasis should be put on:

- education and empowerment;
- integrated packages of care with joint health and social care teams;
- the right incentives for commissioners; and
- intensive use of assistive and home monitoring technologies.

2.45 This integrated model of care can transform the experiences of individuals with long-term conditions, dramatically improving quality of life, health and well-

being. We are therefore developing a number of large-scale pilot sites (serving around one million people in total) that will provide evidence of the effectiveness of this approach.

2.46 The application prospectus for NHS and local authority partners interested in becoming a pilot is being finalised, and expressions of interest will be invited from those wishing to be involved in the programme. Successful partnerships will be supported through a detailed planning phase prior to implementation.

2.47 Ongoing work with the NHS Purchasing and Supply Agency (PASA) and CSIP has been aimed at gathering intelligence on developments in the integrated care and telehealth/telecare sectors and at defining the procurement options for the pilots. In parallel, we have been working with the Department of Trade and Industry on how to stimulate UK industry interest in this sector. NHS Connecting for Health has been providing support in identifying the key technical barriers to the scalability of telehealth/telecare.

Commitment	Progress	Next steps
New Deal for Carers.	Dedicated helpline: scoping specification. Expert Carers Programme. Wide consultation as to content and impact of programme completed. Emergency home-respite scheme: identifying existing good practice.	Delivery model currently being developed (in conjunction with carers' organisation). Detailed action planning for roll-out 2007/08.
National framework for NHS funded adult continuing care and nursing care.	National consultation exercise undertaken from June to September 2006. Analysis of consultation is currently underway.	Response to consultation to be published late 2006, to set out timetable for implementation and next steps. Framework for Children currently in the planning stage.

3 'Architecture and Wiring': supporting change

3.1 The White Paper goals can only be met if health and social care systems are designed in ways that help staff to deliver these major shifts.

Reform in the NHS

3.2 'Health Reform in England – update and commissioning framework' published in the summer of this year, outlines the progress that has been made towards a framework that will help to transform the way in which services are delivered and will, as it develops, support staff in delivering the White Paper shifts. It is an approach that gives local commissioners clear responsibility for understanding the needs of their communities, and ensuring that high quality services are in place to meet those needs.

3.3 The other key components of the approach – greater choice and a stronger voice for people using services, more diverse providers with freedom to innovate and develop approaches that work for those individuals, and money following people using services to reward responsive providers – should all work together over time to build a genuinely 'patient-led' service that supports people in looking after their own health and well-being.

3.4 A number of the key building blocks to support the White Paper are falling into place.

Practice based commissioning

3.5 Practice based commissioning (PBC) is giving primary health care teams the freedom and incentives to develop new models of support for service users, which build on prevention and early intervention, and avoid unnecessary stays in hospital. Currently 74 per cent of all practices in England have taken up an incentive payment and have started to engage in PBC.

Using practice based commissioning to support joint working between health and social care

Practice based commissioning is being used by a practice in South West Staffordshire to set up community teams to handle cases requiring a mix of health and social care expertise. A practice based social worker is part of the community team.

Teams also make use of consultants in mental health, older people and a range of other specialities now based within primary care. This integration of primary and secondary care workforces has given new impetus in avoiding hospital admissions.

Through the secondment of a team of community nurses, which, with the practice's own, has formed an integrated nursing team, the increased skill mix of the workforce has improved the practice's capacity to deliver a robust approach to integrated patient care.

Helped by a grant from the Alzheimer's Society, the practice has also purchased a local residential home, ensuring that daytime respite care is easily accessible. This approach is being further supported through the local voluntary organisation-driven 'Living for the Future' scheme, which facilitates befriending and peer support for older people.

Social Enterprise

3.6 A Social Enterprise Unit has been established to work with SHAs, local authorities and other partners to provide national and localised support and information to social enterprises. This year the Unit will identify 10–15 pathfinders who want to develop new models to deliver health and social care services, and who want to help spread best practice and share learning. Pathfinders will receive financial support from this year's Social Enterprise Fund. This is in addition to the promised Social Enterprise Fund from April 2007.

Payment by Results

3.7 The Payment by Results (PbR) programme has established the arrangements for funding NHS providers of acute care, and is now examining steps to support shifting care through 'unbundling' to differentiate between the different stages of a patient's care pathway and support parts of care packages being delivered in community settings. Developing PbR to enable the tariff to be applied regardless of the type of provider or the setting in which the care is

Sandwell Community Caring Trust

Sandwell Community Caring Trust (SCCT) provides care and supported living to children, adults and older people with disabilities.

Since being created in 1997 by transferring services from the council, SCCT has made impressive savings. For example, an elderly care home run by the Council at a cost of £452 per person per week, and transferred to SCCT in 1997, now costs just £328 per person per week to run.

Crucially, the Trust's achievements have been made without sacrificing quality or staff pay and conditions. SCCT's 294 staff still enjoys local authority terms of employment and the Trust came second in the 2006 Sunday Times 100 Best Companies to Work for. The Trust had the happiest employers of all 100 companies, and this has not only had a positive impact on the quality of care for users, but also reduced staff absenteeism to 0.6 days per person from 22 days in 1997 and contributed to a staff turnover of less than 4 per cent.

Service users and their families have witnessed a dramatic improvement in the quality of accommodation offered and in the quality of care provided. Services are now genuinely targeted at the needs of individuals and based upon personal care plans. Changes in need are responded to rapidly.

delivered will also provide financial incentives for commissioners to move care into the most cost-effective setting. The next version of the Health Resource Groups¹, which is currently in development, will introduce the concept of setting independence. Initial work on unbundling has centred on the development of an unbundled tariff for the 'focus areas' identified in the White Paper, such as the specialties for the shifting care closer to home demonstration sites. Indicative prices for the diagnostic and rehabilitation elements of a few exemplar HRGs will be published for use in 2007/08. This will be coupled with a change in emphasis in guidance on PbR to require tariffs to be unbundled locally wherever delivery of an HRG is split between more than one provider.

Commissioning

3.8 *Health Reform in England: update and commissioning framework* seeks views on a number of proposals that take forward the White Paper, in particular the introduction of petitions to act as 'triggers' for a review of local services.

3.9 A Third Sector Commissioning Task Force was set up to address the obstacles to a level playing field for third sector providers in regulation, commissioning, procuring and contracting for health and social care services. Its report *No excuses. Embrace partnership now*, was published in July 2006.

Framework for joint working

3.10 The White Paper committed us to supporting joint working between health and social care by examining the scope for a joint outcomes framework (building on the seven outcomes in *Independence, well-being and choice*), aligning performance assessment regimes, making greater use of

Local Area Agreements (LAAs) to support planning across local services, and aligning local authority and NHS budget and planning cycles.

3.11 The first annual reviews of the pilot LAAs showed strong performance across a number of health and social care priorities. LAAs have proved an important catalyst for improved partnership working in a number of areas, encouraging creativity and innovation by focusing on outcomes, and increasing capacity through partnership and joint accountability. By March 2007, all local authority areas should have an LAA, including a mandatory section on tackling health inequalities.

3.12 The NHS Operating Framework for 2007/08 will set out the framework of priorities, expectations and rules for the NHS to operate in 2007/08 and will be published by the turn of the year. The commitment to aligning NHS and local authority budgetary cycles will be embedded in the development of the performance framework for the Comprehensive Spending Review in 2007.

Local Government White Paper

3.13 The Local Government White Paper will provide further impetus to the direction of travel set out in *Our health, our care, our say* by making it easier for local authorities and NHS bodies to work together in agreeing local priorities and targets.

3.14 We are committed to cutting the amount of red tape, so that there are fewer centrally determined targets and indicators, and greater flexibility for local partners to react to local circumstances. This will provide the room for health and social care partners to work towards shared outcomes, for example, using expanded joint commissioning and an increased use of Health Act flexibilities.

¹Health Resource Groups (HRGs) – the currency used in the national tariff.

Workforce

3.15 Implementing the White Paper changes will give many staff the freedom to work in a wide range of settings and consider innovative approaches to care. It will offer staff the chance to work in multi-disciplinary teams with greater specialist input, as more care is shifted into community settings. Staff will also be offered the opportunity to take on more new roles and responsibilities, for example as practitioners with a special interest.

3.16 As local services work to redesign pathways and new models of care, there will be consequences for how, where and with whom staff work. Development work is underway to look at the workforce consequences, including workforce flexibilities, role design, skills and competencies, and education and training. This work is being undertaken with employers, trade unions and professional bodies, and other bodies, including Skills for Care and Skills for Health. A White Paper Workforce Issues Group, jointly chaired by the Director General of Workforce at the Department of Health and a union representative, has identified themes for future work including:

- integrated commissioning and strategic workforce planning;
- new ways of working; and
- education and training.

3.17 *Health Reform in England* has already set out some of the principles and practical steps being taken to address NHS workforce issues. *Modernising nursing careers: setting the direction*, outlines potential new opportunities for nurses. Work has already begun on supporting nurses to move from hospital to the community, and NHS Employers is publishing a briefing for employers later this year.

3.18 A further enabler for change will be the Options for Excellence review. The review was established jointly by the Department of Health and the Department for Education and Skills to look at ways to address workforce issues in social care. Issues examined have included: the reform of recruitment and retention practices within the sector; how to ensure that all parts of the social care system receive appropriate opportunities for training and development; and how best practice can be disseminated and replicated across the country. The review's final report will be published shortly.

Next steps

3.19 As well as developing the PbR regime to help shift services into community settings, the next stages of health reform will increase the focus on workforce issues, including supporting joint working between health and social care. This includes the development of new preventive approaches and models of care in the community. In particular, we expect to see practice based commissioning become firmly established and, during 2007, begin to have a real impact on service redesign. We will look further at the framework for PBC to ensure that it provides the necessary flexibilities and incentives to support this, for example by enabling general practices to work with social care and other partners and to invest innovatively in a wide range of different forms of community or home support.

3.20 We will also support local authorities and PCTs in undertaking joint strategic needs assessments and joint commissioning through a new commissioning framework, due to be published in winter 2006. This will provide guidance on effective joint commissioning across health and local authority partners, concentrating on how to commission services that promote health and wider well-being, and reduce inequalities. The new framework

will look at how commissioners can respond to the challenges set out in the Third Sector Commissioning Task Force report. It will also look at how commissioners can use a range of tools to understand the requirements of local communities, including 'social

marketing' techniques, outlined in *Health Challenge England*, which can help them to research and differentiate between the needs of different groups within the local community.

Key publications on the horizon

Commissioning framework for health and well-being (winter 2006).

Consultation document on the development of PbR in 2008/09 and beyond.

Consultation on proposals on the future role of the independent regulator and the response to the Wider Regulatory Review.

Choice Framework – focusing on increasing choice, shared decision-making and patient and user empowerment, particularly for people with long-term conditions.



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